Racial and Ethnic Approaches to Community Health (REACH) 2010:

Addressing Disparities in Health

2003

REACH 2010 Project Sites, Fiscal Year 2002

"CDC continues to support phenomenal community coalitions in their quest to eliminate racial and ethnic disparities in health. In turn, these communities are providing invaluable knowledge to CDC and the nation as we continue to promote better health for all Americans."

Julie Louise Gerberding, MD, MPH
Director, CDC, and Administrator, ATSDR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
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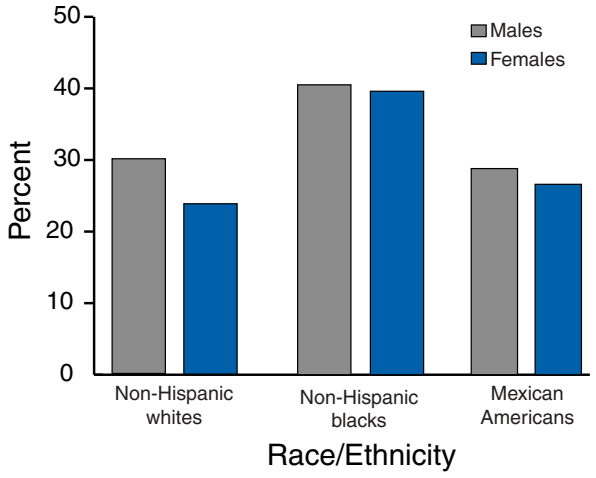
Racial and Ethnic Disparities in Health

Despite great improvements in the overall health of the nation, Americans who are members of racial and ethnic minority groups, including African Americans, Alaska Natives, American Indians, Asian Americans, Hispanic Americans, and Pacific Islanders, are more likely than whites to have poor health and to die prematurely, as the following examples illustrate:

- **Breast and cervical cancer:** Although death rates from breast cancer declined significantly during 1992–1998, they remain higher among black women than among white women. In addition, women of racial and ethnic minorities are less likely than white women to receive Pap tests, which can prevent invasive cervical cancer by detecting precancerous changes in the cervix.
- **Cardiovascular disease:** In 1999, rates of death from diseases of the heart were 29% higher among African Americans than among whites, and death rates from stroke were 40% higher.
- **Diabetes:** Compared with whites, American Indians and Alaska Natives are 2.6 times, African Americans are 2.0 times, and Hispanics are 1.9 times more likely to have diagnosed diabetes.
- **HIV/AIDS:** Although African Americans and Hispanics represent only 25% of the U.S. population, they account for roughly 56% of adult AIDS cases, 73% of new HIV infections among U.S. adults, and 82% of pediatric AIDS cases.
- **Immunizations:** In the1998–2000 National Immunization Survey, 11 major urban areas reported racial/ethnic disparities of greater than 10% for at least one age-appropriate childhood immunization. Additionally, in 2001, Hispanics and African Americans aged 65 or older were less likely than whites to have received influenza and pneumococcal vaccines.
- **Infant mortality:** Although the 2000 U.S. infant mortality rate of 6.9 infant deaths per 1,000 live births was the lowest ever recorded, African American, American Indian, and Puerto Rican infants continue to have higher mortality rates than white infants. In 2000, the black-to-white ratio in infant mortality was 2.5.

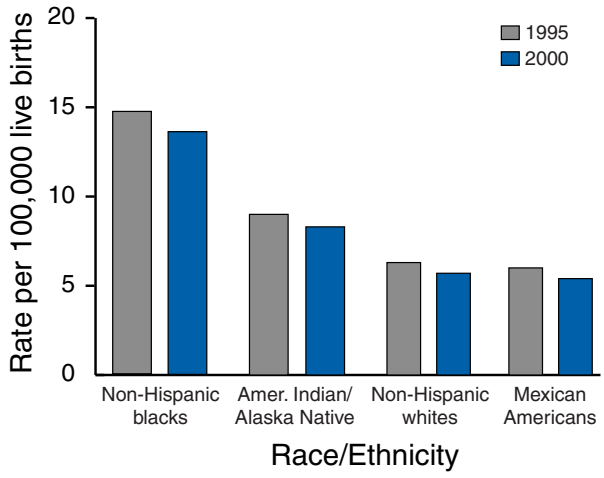
Because racial and ethnic minority groups are expected to comprise an increasingly larger proportion of the U.S. population in coming years, the number of people affected by disparities in health care will only increase without a concerted effort to eliminate these disparities. Culturally appropriate, community-driven programs are critical for eliminating racial and ethnic disparities in health. To be successful, these programs need to be based on sound prevention reseach and supported by new and innovative partnerships among federal, state, local, and tribal governments and communities.

Prevalence of Cardiovascular Disease, by Race/Ethnicity



Source: National Health and Nutrition Examination Survey III, 1988–1994, National Center for Health Statistics, CDC.

U.S. Infant Mortality Rates, by Race/Ethnicity of Mother, 1998



Source: National Center for Health Statistics, CDC

CDC's Leadership Role

Healthy People 2010, which describes the nation's health objectives for the decade, has as one of its goals eliminating racial and ethnic disparities in health. The Centers for Disease Control and Prevention (CDC) has a major leadership role in carrying out the goals set forward in this initiative.

Launching REACH 2010

Racial and Ethnic Approaches to Community Health (REACH) 2010 is the cornerstone of CDC's efforts to eliminate racial and ethnic disparities in health. Launched in 1999, REACH 2010 is designed to eliminate disparities in the following six priority areas: cardiovascular disease, immunizations, breast and cervical cancer screening and management, diabetes, HIV/AIDS, and infant mortality. The racial and ethnic groups targeted by REACH 2010 are African Americans, American Indians, Alaska Natives, Asian Americans, Hispanic Americans, and Pacific Islanders.

REACH 2010 is a two-phase, 5-year demonstration project that supports community coalitions in designing, implementing, and evaluating community-driven strategies to eliminate health disparities. Each coalition comprises a community-based organization and three other organizations, of which at least one is either a local or state health department or a university or research organization.

During a 12-month planning phase, REACH 2010 grantees use local data to develop a community action plan that addresses one or more of the six priority areas and targets one or more of the racial and ethnic minority groups. During the 4-year implementation phase, community coalitions carry out and evaluate activities outlined in their action plans.

In fiscal year 2002, Congress appropriated $37.8 million* to fund 31 REACH 2010 projects and to support the new emphasis on projects in American Indian and Alaska Native communities. Five REACH 2010 core capacity-building projects in American Indian and Alaska Native communities in Albuquerque, NM; Oklahoma City and Talihina, OK; Anchorage, AK; and Nashville, TN, received continuation funding. Four Administration on Aging (AoA) projects also received continuation funding. Funding for 2003 will remain the same as for 2002.

Working With Partners

Other agencies and offices within the U.S. Department of Health and Human Services (HHS) have played critical roles in planning, coordinating, and supporting the REACH 2010 program. In an enormous show of support, the National Institutes of Health contributed $5 million to support five REACH 2010 programs in FY 2000 and has pledged to maintain this level of support over the next 2 years. Through an interagency agreement with the AoA, CDC is providing $2 million over 2 years to continue four projects addressing health disparities in elderly populations. Other partners within HHS include the Office of the Secretary, the Health Resources and Services Administration, and the Agency for Healthcare Research and Quality.

In addition, other public and private agencies are supporting REACH 2010. For example, in fiscal year 2000, the California Endowment provided $9.6 million through the CDC Foundation to implement and evaluate activities over the next 3 years in two California coalitions identified through CDC's REACH 2010 competitive process.

Evaluating REACH 2010

REACH 2010 projects are empowering community members to transform their neighborhoods into places that encourage healthy behaviors. Through close collaboration with community members and creative partnerships with public and private organizations, CDC will continue to spearhead the country's efforts to eliminate health disparities by carrying out the lessons learned from the REACH 2010 projects in communities across the country.

The evaluation of the REACH 2010 program is critical in determining the program's effectiveness in reducing health disparities. Working with its grantees and partners, CDC has developed an evaluation model to guide the collection of national data. This model evaluates programs on their effectiveness in the following areas: building community capacity, developing targeted actions, improving health systems and agents of change, decreasing risk behaviors and increasing protective behaviors, and reducing disparity-related illness and death.

*The National Institutes of Health contributed $5 million to the overall funding of these projects.

REACH 2010 Projects in Action

A critical part of the REACH 2010 strategy is to test the effectiveness of programs to improve the health of racial and ethnic minority populations. The following are examples of REACH 2010 projects:

South Carolina—Targeting diabetes among African Americans

The Medical University of South Carolina/Charleston and Georgetown REACH Diabetes Coalition is an urban-rural coalition working to improve diabetes outcomes for more than 11,012 African Americans with diagnosed diabetes in Charleston and Georgetown counties. The primary goal of the community coalition is to "take the programs to the communities." One of the objectives was for REACH clinic site partners to increase by 20% by 2004 the number of people with diabetes who received the recommended annual A1C test. Encouragingly, this objective was accomplished in the first year of the project. In 1998, 46% of African Americans and 61% of Caucasians received A1C tests. In 2002, 87% of African Americans and 89% of Caucasians were tested.

Texas—Targeting diabetes among Hispanic Americans

The REACH Promotora Community Coalition, supported by the Migrant Health Promotion project, has developed a program to address diabetes along the border of Texas and Mexico. The coalition targets residents of Hildago and Cameron counties, more than 80% of whom are Mexican American. The diabetes prevalence rates in these two counties are 17% and 23%, respectively, compared with just under 6% in the U.S. population. Developing the full potential of the community health workers (promotoras) as they gain experience and training as community organizers, program planners, and program evaluators is a key part of this program. Because the target population lives in communities that have little infrastructure and lacks access to transportation or telephones, the promotoras use existing institutions such as public schools, community health clinics, and community-based organizations and conduct much of their work through home visits and neighborhood meetings.

Michigan—Targeting infant mortality among African Americans

The Genesee County Precious Black Babies Project, in Flint, Michigan, emphasizes reducing racial disparities in infant mortality through population-focused interventions that embody cultural understanding, sensitivity, and relevance. The project has created a campaign to raise awareness among community residents about racial disparities in infant death rates and to help reduce these disparities. Community events sponsored by the project and a faith-based health team network have provided a forum for disseminating information on reducing African American infant mortality.

California—Targeting breast and cervical cancer among Asian Americans

Promoting Access to Health (PATH) for Women, developed by the Special Services for Groups, Inc., and funded by the California Endowment through the CDC Foundation, is a Los Angeles-area collaboration that focuses on decreasing disparities in breast and cervical cancer rates among Asian American and Pacific Islander women. The project draws on Pacific Islander and Southeast Asian community leaders and health care providers to develop customized community action plans and materials for each of the seven ethnic groups represented (Cambodian, Laotian, Thai, Vietnamese, Chamorro, Samoan, and Tongan). Each ethnic group then implements its plan at its own level of readiness. The Samoan National Nurses Association is one group that is executing almost all facets of the program, including offering community outreach and education services, promoting a cancer ministries program with local Samoan pastors, establishing a cancer support group, and setting up mobile screening programs for community women.

For more information or additional copies of this document, please contact the Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Mail Stop K–45, 4770 Buford Highway NE, Atlanta, GA 30341-3717; (770) 488-5269.
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